OMB Approved No: 2900-0016
Respondent Burden: 1 hour 15 minutes

Department of Veterans Affairs

CLAIM FOR DISABILITY INSURANCE BENEFITS
GOVERNMENT LIFE INSURANCE

PRIVACY ACT INFORMATION: No benefits may be granted unless a completed application has been received (38 U.S.C. 1912, 1915, 1942, and 1948). The information provided on a voluntary basis will be used by VA employees and your authorized representatives in the maintenance of Government insurance programs. Responses may be disclosed outside VA only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 36VA00, Veterans and Armed Forces Personnel U. S. Government Life Insurance Records - VA, published in the Federal Register.

RESPONDENT BURDEN: Public reporting burden for this collection of information is estimated to average 1 hour 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Clearance Officer (723), 810 Vermont Ave., NW, Washington, DC 20420; and to the Office of Management and Budget, Paperwork Reduction Project (2900-0016), Washington, DC 20503. PLEASE DO NOT SEND THIS FORM OR APPLICATIONS FOR BENEFITS TO THESE ADDRESSES.

INFORMATION AND INSTRUCTIONS

THIS APPLICATION IS TO BE COMPLETED BY VETERANS WHO HAVE GOVERNMENT LIFE INSURANCE AND BECOME TOTALLY DISABLED.

TOTAL DISABILITY - Is any impairment of mind or body which continuously makes it impossible for the veteran to follow any substantially gainful occupation. Total Disability must be continuous from a date prior to the veteran's 65th birthday.

WAIVER REFUND - Refund of premiums paid is limited to one year prior to the date the veteran's claim is filed, unless there were circumstances beyond the veteran's control which prevented timely filing of claim. Circumstances include documented evidence showing severe mental disability. **Lack of knowledge of the waiver provision is not a circumstance beyond the veteran's control.** If you claim total disability beginning more than one year prior to the date of your claim and you believe that mental disability prevented your filing an earlier claim, please include a statement explaining these circumstances on a separate sheet of paper. **You should also include any available medical evidence which supports your statement.**

PART I should be completed by the insured veteran if able; if not, by a person acting on his/her behalf.

PART II should be completed by the insured veteran's physician or hospital official. If there will be a delay in preparing Part II send Part I immediately.

NOTE: IF THE VETERAN HAS BEEN GRANTED DISABILITY BENEFITS FROM THE SOCIAL SECURITY ADMINISTRATION, PLEASE ATTACH A COPY OF THE AWARD LETTER.

PART I

1. FIRST, MIDDLE, LAST NAME OF INSURED *(Type or print)*	2. INSURANCE FILE NUMBER *(Include letter prefix)*
3. MAILING ADDRESS FOR INSURANCE PURPOSES *(Number and street or rural route, city or P.O., State and ZIP Code)*	4. SOCIAL SECURITY NUMBER
	5. DATE OF BIRTH
	6. DAYTIME TELEPHONE NUMBER *(Include Area Code)*
	7. CLAIM NUMBER

8. DATE DISABILITY PREVENTED EMPLOYMENT	9. DATE RETURNED TO GAINFUL EMPLOYMENT

10A. EDUCATION *(Circle highest years completed) (If you have any other specialized training or education please complete Item 10B)*

1 2 3 4 5 6 7 8	1 2 3 4	1 2 3 4
(Grade School)	*(High School)*	*(College)*

10B. PLEASE PROVIDE ANY SPECIALIZED TRAINING IN THE SPACE PROVIDED BELOW

11. ARE YOU RECEIVING OR HAVE YOU APPLIED FOR ANY DISABILITY BENEFITS AS LISTED BELOW?	12. DISEASE OR INJURY CAUSING TOTAL OR PERMANENT DISABILITY
☐ VA DISABILITY COMPENSATION ☐ VA PENSION ☐ SOCIAL SECURITY DISABILITY	